STATE OF ARIZONA

Application for Serial Number
Initiative Petition
A.R.S. § 19-111

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The undersigned intends to circulate and file an initiative petition and hereby makes application for the issuance of an official serial number to be printed in the lower right-hand corner of each side of each signature sheet of such petition. Attached hereto is the full title and text, in no less than eight point type, of the measure or constitutional amendment intended to be initiated at the next general election.

☒ **Statutory Measure** ☐ **Constitutional Amendment**

Date of Application	8-26-2019
Signatures Required	237,645
Deadline for Filing	7-2-2020
Serial Number Issued	I-20-2020

The Stop Surprise Billing and Protect Patients Act prohibits insurers from discriminating based on preexisting conditions. Redefines "surprise out-of-network bill" to mean billing above in-network cost-sharing requirements, and bans such bills; also bans balance bills for ambulance care; insurers must reimburse providers, facilities and ambulances at specified rates. Sets new minimum wages for direct care workers at private hospitals through raises of at least five percent each of four years. Private hospitals must meet national safety standards regarding hospital-acquired infections, under Department of Health Services enforcement authority, funded by fees paid by private hospitals.

Suzanne Jimenez
Name of Applicant

2239 West Baseline Road
Address

Tempe AZ 85283
City **State** **Zip**

480.588.6120
Telephone Number

james@thetorresfirm.com
E-mail Address

ARIZONANS FED UP WITH FAILING HEALTHCARE (HEALTHCARE RISING AZ)
Committee Name

100082
Committee ID No.

JENNIFER DAVID
Chairperson

SUZANNE JIMENEZ
Treasurer

2239 W Baseline Raod
Committee Address

Tempe AZ 85283
City **State** **Zip**

480.588.6120
Committee Telephone Number

james@thetorresfirm.com
Committee E-mail Address

By submitting this Application for Serial Number and checking all boxes below, I acknowledge the following:

☑ That I have received and will review the accompanying Instructions for Statewide Initiatives, including the Secretary of State's recommended best practices for printing copies of the Statewide Initiative Petition to be circulated.

☑ That at the time of filing, I was provided instructions regarding accurate completion of the Statewide Initiative Petition form.

Suzanne Jimenez
Applicant Signature

8/26/19
Date

Office of the Secretary of State
1700 W. Washington Street
Phoenix, Arizona 85007

Rev. 03/04/2019

OFFICIAL TITLE
AN INITIATIVE MEASURE

AMENDING TITLE 20, CHAPTER 1 ARIZONA REVISED STATUTES, BY ADDING ARTICLE 5; AMENDING SECTIONS 20-3111 THROUGH 20-3113, AND ADDING 20-3113.01 ARIZONA REVISED STATUTES; AMENDING TITLE 23, CHAPTER 2, ARIZONA REVISED STATUTES, BY ADDING SECTION 23-363.01; AMENDING TITLE 36, CHAPTER 25 ARIZONA REVISED STATUTES, BY ADDING ARTICLE 3; RELATING TO HEALTHCARE BILLING REFORM, MINIMUM WAGE FOR DIRECT CARE HOSPITAL WORKERS, AND CONTROL OF HOSPITAL-ACQUIRED INFECTIONS.

TEXT OF PROPOSED AMENDMENT

Be it enacted by the People of the State of Arizona:

Section 1. Title 20, Chapter 1, Arizona Revised Statutes, is amended by adding a new article 5 to read:

ARTICLE 5. PROHIBITION OF DISCRIMINATION BASED UPON PREEXISTING CONDITIONS.

§ 20-192. NO EXCLUSIONS FROM HEALTH INSURANCE COVERAGE BASED UPON PREEXISTING CONDITIONS.

A HEALTH CARE INSURER OFFERING HEALTH INSURANCE COVERAGE IN THE STATE OF ARIZONA SHALL NOT IMPOSE ANY PREEXISTING CONDITION EXCLUSION WITH RESPECT TO THE ISSUANCE, RENEWAL, OR SCOPE OF BENEFITS PROVIDED IN SUCH COVERAGE.

§ 20-193. GUARANTEED ISSUANCE OF COVERAGE IN THE INDIVIDUAL AND GROUP MARKET.

A. SUBJECT TO SUBSECTIONS (B) THROUGH (D), A HEALTH CARE INSURER THAT OFFERS HEALTH INSURANCE COVERAGE IN THE INDIVIDUAL OR GROUP MARKET IN THE STATE OF ARIZONA SHALL NOT DENY COVERAGE TO ANY EMPLOYER OR INDIVIDUAL IN THE APPLICABLE MARKET IN ARIZONA THAT APPLIES FOR SUCH COVERAGE.

B. A HEALTH CARE INSURER THAT OFFERS HEALTH INSURANCE COVERAGE IN THE GROUP OR INDIVIDUAL MARKET THROUGH A NETWORK PLAN MAY

1. IN THE GROUP MARKET, LIMIT THE EMPLOYERS WHO MAY APPLY FOR SUCH COVERAGE TO THOSE WITH ELIGIBLE INDIVIDUALS WHO LIVE, WORK, OR RESIDE WITHIN THE NETWORK PLAN'S SERVICE AREA; AND

2. WITHIN THE SERVICE AREA OF SUCH PLAN, DENY COVERAGE TO OTHERWISE ELIGIBLE EMPLOYERS AND INDIVIDUALS UPON DEMONSTRATING TO THE DIRECTOR THAT

a. IT LACKS THE CAPACITY TO DELIVER ADEQUATE SERVICES TO ANY ADDITIONAL ENROLLEES DUE TO ITS OBLIGATIONS TO EXISTING GROUP CONTRACT HOLDERS AND ENROLLEES; AND

b. IT IS DENYING COVERAGE ON A NON-DISCRIMINATORY BASIS, WITHOUT REGARD TO THE CLAIMS EXPERIENCE OR ANY HEALTH STATUS FACTORS OF SUCH INDIVIDUALS OR SUCH EMPLOYERS AND THEIR EMPLOYEES AND THEIR EMPLOYEES' DEPENDENTS.

C. A HEALTH CARE INSURER MAY DENY HEALTH INSURANCE COVERAGE IN THE GROUP OR INDIVIDUAL MARKET UPON DEMONSTRATING TO THE DIRECTOR THAT

1. IT DOES NOT HAVE THE FINANCIAL RESERVES NECESSARY TO UNDERWRITE ADDITIONAL COVERAGE; AND

2. IT IS DENYING COVERAGE ON A NON-DISCRIMINATORY BASIS, WITHOUT REGARD TO THE CLAIMS EXPERIENCE OR ANY HEALTH STATUS FACTORS OF SUCH INDIVIDUALS OR SUCH EMPLOYERS AND THEIR EMPLOYEES AND THEIR EMPLOYEES' DEPENDENTS.

D. UPON DENYING HEALTH INSURANCE COVERAGE PURSUANT TO SUBSECTIONS (C)(2) OR (D), A HEALTH CARE INSURER IS PROHIBITED FROM OFFERING COVERAGE IN THE GROUP OR INDIVIDUAL MARKET FOR A PERIOD OF 180 DAYS AFTER THE DATE SUCH COVERAGE IS DENIED.

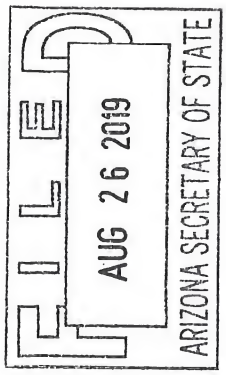
§ 20-194. GUARANTEED RENEWABILITY OF COVERAGE.

A. SUBJECT TO SUBSECTION (B), EACH HEALTH CARE INSURER THAT OFFERS HEALTH INSURANCE COVERAGE IN THE INDIVIDUAL OR GROUP MARKET MUST RENEW OR CONTINUE IN FORCE SUCH COVERAGE AT THE OPTION OF THE PLAN SPONSOR OR THE INDIVIDUAL, AS APPLICABLE.

B. A HEALTH CARE INSURER MAY DECLINE TO RENEW OR MAY DISCONTINUE HEALTH INSURANCE COVERAGE OFFERED IN THE GROUP OR INDIVIDUAL MARKET ONLY IF SUCH NONRENEWAL OR DISCONTINUANCE IS BASED ON ONE OR MORE OF THE FOLLOWING GROUNDS FOR EXCEPTION:

1. THE PLAN SPONSOR, OR INDIVIDUAL, AS APPLICABLE, HAS FAILED TO PAY PREMIUMS OR CONTRIBUTIONS IN ACCORDANCE WITH THE TERMS OF THE HEALTH INSURANCE COVERAGE OR THE ISSUER HAS NOT RECEIVED TIMELY PREMIUM PAYMENTS.

2. THE PLAN SPONSOR, OR INDIVIDUAL, AS APPLICABLE, HAS PERFORMED AN ACT OR PRACTICE THAT CONSTITUTES FRAUD OR MADE AN INTENTIONAL MISREPRESENTATION OF MATERIAL FACT UNDER THE TERMS OF THE COVERAGE.



3. IN THE CASE OF A GROUP HEALTH PLAN, THE PLAN SPONSOR HAS FAILED TO COMPLY WITH A MATERIAL PLAN PROVISION RELATING TO EMPLOYER CONTRIBUTION OR GROUP PARTICIPATION RULES, PURSUANT TO APPLICABLE LAW.

4. THE ISSUER IS CEASING TO OFFER COVERAGE IN THE GROUP OR INDIVIDUAL MARKET IN ACCORDANCE WITH APPLICABLE LAW.

5. IN THE CASE OF A HEALTH CARE INSURER THAT OFFERS HEALTH INSURANCE COVERAGE IN THE MARKET THROUGH A NETWORK PLAN, THERE IS NO LONGER ANY ENROLLEE IN CONNECTION WITH SUCH PLAN WHO LIVES, RESIDES, OR WORKS IN THE SERVICE AREA OF THE INSURER (OR IN THE AREA FOR WHICH THE INSURER IS AUTHORIZED TO DO BUSINESS).

6. IN THE CASE OF HEALTH INSURANCE COVERAGE THAT IS MADE AVAILABLE IN THE SMALL OR LARGE GROUP MARKET ONLY THROUGH ONE OR MORE BONA FIDE ASSOCIATIONS, THE MEMBERSHIP OF AN EMPLOYER IN THE ASSOCIATION (ON THE BASIS OF WHICH THE COVERAGE IS PROVIDED) CEASES BUT ONLY IF SUCH COVERAGE IS TERMINATED UNDER THIS PARAGRAPH UNIFORMLY WITHOUT REGARD TO ANY HEALTH STATUS-RELATED FACTOR RELATING TO ANY COVERED INDIVIDUAL.

§ 20-195. RATING RESTRICTIONS.

A. THE PREMIUM RATE CHARGED BY A HEALTH CARE INSURER FOR HEALTH INSURANCE COVERAGE OFFERED IN THE INDIVIDUAL OR SMALL GROUP MARKET, OR IN THE LARGE GROUP MARKET THROUGH A STATE EXCHANGE, MAY VARY BASED ONLY ON THE FOLLOWING FACTORS:

1.WHETHER SUCH PLAN OR COVERAGE COVERS AN INDIVIDUAL OR FAMILY;

2. GEOGRAPHIC RATING AREAS THAT ARE OR MAY BE ESTABLISHED BY THE DIRECTOR;

3. AGE, ACCORDING TO AGE BANDS THAT ARE OR MAY BE ESTABLISHED BY THE DIRECTOR, EXCEPT THAT SUCH RATE SHALL NOT VARY BY MORE THAN 3 TO 1 FOR ADULTS; AND

4. TOBACCO USE, EXCEPT THAT SUCH RATE SHALL NOT VARY BY MORE THAN 1.5 TO 1, OR UNDER APPLICABLE FEDERAL LAW, WHICHEVER IS LOWER.

B. WITH RESPECT TO FAMILY HEALTH INSURANCE COVERAGE, THE RATING VARIATIONS PERMITTED UNDER SUBSECTIONS (A)(3) AND (A)(4) SHALL BE APPLIED BASED ON THE PORTION OF THE PREMIUM THAT IS ATTRIBUTABLE TO EACH COVERED FAMILY MEMBER.

§ 20-196. DEFINITIONS.

IN THIS ARTICLE, THE FOLLOWING TERMS ARE USED AS DEFINED:

1. "DIRECTOR" MEANS THE DIRECTOR OF THE DEPARTMENT OF INSURANCE.

2. "GROUP HEALTH PLAN" MEANS A PLAN COVERING EMPLOYEES OF AN EMPLOYER AS DEFINED IN § 607(A) OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

3. "GROUP MARKET" MEANS THE HEALTH INSURANCE MARKET UNDER WHICH INDIVIDUALS OBTAIN HEALTH INSURANCE COVERAGE (DIRECTLY OR THROUGH ANY ARRANGEMENT) ON BEHALF OF THEMSELVES (AND THEIR DEPENDENTS) THROUGH A GROUP HEALTH PLAN MAINTAINED BY A LARGE OR SMALL EMPLOYER.

4. "HEALTH CARE INSURER" MEANS A DISABILITY INSURER, GROUP DISABILITY INSURER, BLANKET DISABILITY INSURER, HEALTH CARE SERVICES ORGANIZATION, HOSPITAL SERVICE CORPORATION, MEDICAL SERVICE CORPORATION OR A HOSPITAL, MEDICAL, DENTAL AND OPTOMETRIC SERVICE CORPORATION.

5. "HEALTH CARE PLAN" MEANS ANY CONTRACTUAL ARRANGEMENT WHEREBY ANY HEALTH CARE SERVICES ORGANIZATION UNDERTAKES TO PROVIDE DIRECTLY OR TO ARRANGE FOR ALL OR A PORTION OF CONTRACTUALLY COVERED HEALTH CARE SERVICES AND TO PAY OR MAKE REIMBURSEMENT FOR ANY REMAINING PORTION OF THE HEALTH CARE SERVICES ON A PREPAID BASIS THROUGH INSURANCE OR OTHERWISE.

6. "HEALTH CARE SERVICES ORGANIZATION" MEANS ANY PERSON THAT UNDERTAKES TO CONDUCT ONE OR MORE HEALTH CARE PLANS. UNLESS THE CONTEXT OTHERWISE REQUIRES, HEALTH CARE SERVICES ORGANIZATION INCLUDES A PROVIDER SPONSORED HEALTH CARE SERVICES ORGANIZATION.

7. "HEALTH INSURANCE COVERAGE" MEANS BENEFITS CONSISTING OF MEDICAL CARE (PROVIDED THROUGH INSURANCE SUBJECT TO THIS CODE) UNDER ANY HOSPITAL OR MEDICAL SERVICE POLICY OR CERTIFICATE, HOSPITAL OR MEDICAL SERVICE PLAN CONTRACT, OR HEALTH MAINTENANCE ORGANIZATION CONTRACT OFFERED BY A HEALTH CARE INSURER, WHETHER ON THE GROUP MARKET OR INDIVIDUAL MARKET. "HEALTH INSURANCE COVERAGE" INCLUDES SHORT-TERM LIMITED DURATION INSURANCE.

8. "INDIVIDUAL MARKET" MEANS THE MARKET FOR HEALTH INSURANCE COVERAGE OFFERED TO INDIVIDUALS OTHER THAN IN CONNECTION WITH A GROUP HEALTH PLAN.

9. "MEDICAL CONDITION" MEANS ANY CONDITION, WHETHER PHYSICAL OR MENTAL, INCLUDING, BUT NOT LIMITED TO, ANY CONDITIONS RESULTING FROM ILLNESS, INJURY (WHETHER OR NOT THE INJURY IS ACCIDENTAL), PREGNANCY, OR CONGENITAL MALFORMATION.

10. "NETWORK PLAN" MEANS HEALTH CARE SERVICES THAT ARE PROVIDED BY A HEALTH CARE SERVICES ORGANIZATION UNDER WHICH THE FINANCING AND DELIVERY OF HEALTH CARE SERVICES ARE PROVIDED, IN WHOLE OR IN PART, THROUGH A DEFINED SET OF PROVIDERS UNDER CONTRACT WITH THE HEALTH CARE SERVICES ORGANIZATION.

11. "PREEXISTING CONDITION EXCLUSION" MEANS A LIMITATION OR EXCLUSION OF BENEFITS RELATING TO A MEDICAL CONDITION BASED ON THE FACT THAT THE CONDITION WAS PRESENT BEFORE THE DATE OF ENROLLMENT FOR INSURANCE COVERAGE, REGARDLESS OF WHETHER ANY MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS RECOMMENDED OR RECEIVED BEFORE SUCH DATE.

12. "SHORT-TERM LIMITED DURATION INSURANCE" MEANS BENEFITS OFFERED BY A HEALTH CARE INSURER THAT HAS AN EXPIRATION DATE SPECIFIED IN THE CONTRACT THAT IS LESS THAN TWELVE MONTHS AFTER THE ORIGINAL EFFECTIVE DATE OF THE CONTRACT AND, TAKING INTO ACCOUNT RENEWALS OR EXTENSIONS, THAT HAS A DURATION OF NOT LONGER THAN THIRTY-SIX MONTHS.

13. "STATE EXCHANGE" MEANS AN AMERICAN HEALTH BENEFIT EXCHANGE ESTABLISHED BY ARIZONA PURSUANT TO 42 U.S.C. § 18031.

Sec. 2. Heading change

The article heading of title 20, chapter 20, article 2, Arizona Revised Statutes, is changed from "Out of Network Claim Dispute Resolution" to "FAIR BILLING PRACTICES".

Sec. 3. Section 20-3111, Arizona Revised Statutes, is amended to read:

§ 20-3111. Definitions

In this article, unless the context otherwise requires:

1. "AMBULANCE" MEANS ANY PUBLICLY OR PRIVATELY OWNED SURFACE VEHICLE THAT CONTAINS A STRETCHER AND NECESSARY MEDICAL EQUIPMENT AND SUPPLIES PURSUANT TO § 36-2202 AND THAT IS ESPECIALLY DESIGNED AND CONSTRUCTED OR MODIFIED AND EQUIPPED TO BE USED, MAINTAINED OR OPERATED PRIMARILY FOR THE TRANSPORTATION OF INDIVIDUALS WHO ARE SICK, INJURED OR WOUNDED OR WHO REQUIRE MEDICAL MONITORING OR AID. AMBULANCE DOES NOT INCLUDE A SURFACE VEHICLE THAT IS OWNED AND OPERATED BY A PRIVATE SOLE PROPRIETOR, PARTNERSHIP, PRIVATE CORPORATION OR MUNICIPAL CORPORATION FOR THE EMERGENCY TRANSPORTATION AND IN-TRANSIT CARE OF ITS EMPLOYEES OR A VEHICLE THAT IS OPERATED TO ACCOMMODATE AN INCAPACITATED PERSON OR PERSON WITH A DISABILITY WHO DOES NOT REQUIRE MEDICAL MONITORING, CARE OR TREATMENT DURING TRANSPORT AND THAT IS NOT ADVERTISED AS HAVING MEDICAL EQUIPMENT AND SUPPLIES OR AMBULANCE ATTENDANTS.

2. "AMBULANCE SERVICE" MEANS A PERSON WHO OWNS OR OPERATES ONE OR MORE AMBULANCES.

~~1.~~ 3. "Arbitration" means a dispute resolution process in which an impartial arbitrator determines the dollar amount a health care provider is entitled to receive for payment of a surprise out-of-network bill.

~~2.~~ 4. "Arbitrator" means an impartial person who is appointed to conduct an arbitration.

5. "AVERAGE CONTRACTED RATE" MEANS THE AVERAGE OF THE COMMERCIAL CONTRACTED RATES PAID BY A HEALTH PLAN FOR THE SAME OR SIMILAR SERVICES IN THE GEOGRAPHIC AREA COVERED BY THE HEALTH PLAN DURING THE PRECEDING CALENDAR YEAR.

~~3.~~ 6. "Billing company" means any affiliated or unaffiliated company that is hired by a health care provider or health care facility to coordinate the payment of bills with health insurers and to generate or bill and collect payment from enrollees on the health care provider's or health care facility's behalf.

~~4.~~ 7. "Contracted provider" means a health care provider that has entered into a contract with a health insurer to provide health care services to the health insurer's enrollees at agreed on rates.

~~5.~~ 8. "Cost sharing requirements" means an enrollee's applicable ~~out-of-network~~ coinsurance, copayment and deductible requirements ~~under a health plan based on the adjudicated claim~~.

~~6.~~ 9. "Emergency services" has the same meaning prescribed in § 20-2801.

~~7.~~ 10. "Enrollee" means an individual who is eligible to receive benefits through a health plan.

11. "GEOGRAPHIC REGION" MEANS, AS TO THE PROVISIONS OF THIS ARTICLE REQUIRING A DETERMINATION OF THE AMOUNT MEDICARE REIMBURSES ON A FEE-FOR-SERVICE BASIS, THE REGION SPECIFIED FOR PHYSICIAN REIMBURSEMENT FOR MEDICARE FEE-FOR-SERVICE BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

~~8.~~ 12. "Health care facility" has the same meaning prescribed in § 36-437.

~~9.~~ 13. "Health care provider" means a person who is licensed, registered or certified as a health care professional under title 32 or a laboratory or durable medical equipment provider that furnishes services to a patient in a ~~network~~ facility and that separately bills the patient for the services.

~~10.~~ 14. "Health care services" means treatment, services, medications, tests, equipment, devices, durable medical equipment, laboratory services or supplies rendered or provided to an enrollee for the purpose of diagnosing, preventing, alleviating, curing or healing human disease, illness or injury.

~~11.~~ 15. "Health insurer" means a disability insurer, group disability insurer, blanket disability insurer, hospital service corporation or medical service corporation that provides health insurance in this state.

~~12.~~ 16. "Health plan" means a group or individual health plan that finances or furnishes health care services and that is issued by a health insurer.

~~13.~~ 17. "Network facility" means a health care facility that has entered into a contract with a health insurer to provide health care services to the health insurer's enrollees at agreed on rates.

18. "OUT-OF-NETWORK AMBULANCE" MEANS AN AMBULANCE OR AMBULANCE SERVICE THAT HAS NOT ENTERED INTO A CONTRACT WITH AN ENROLLEE'S HEALTH INSURER TO ATTEND OR TRANSPORT THE HEALTH INSURER'S ENROLLEES AT AGREED ON RATES.

19. "OUT-OF-NETWORK FACILITY" MEANS A HEALTH CARE FACILITY THAT HAS NOT ENTERED INTO A CONTRACT WITH AN ENROLLEE'S HEALTH INSURER TO PROVIDE HEALTH CARE SERVICES TO THE HEALTH INSURER'S ENROLLEES AT AGREED ON RATES.

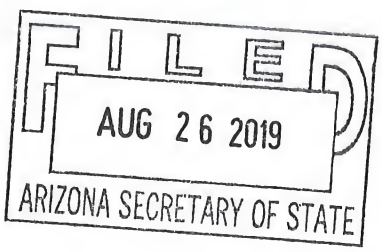
20. "OUT-OF-NETWORK PROVIDER" MEANS A HEALTH CARE PROVIDER THAT HAS NOT ENTERED INTO A CONTRACT WITH AN ENROLLEE'S HEALTH INSURER TO PROVIDE HEALTH CARE SERVICES TO THE HEALTH INSURER'S ENROLLEES AT AGREED ON RATES.

~~14.~~ 21. "Surprise out-of-network bill" ~~means a bill for a health care service that was provided in a network facility by a health care provider that is not a contracted provider and that meets one of the requirements listed~~ HAS THE SAME MEANING PRESCRIBED in § 20-3113.

Sec. 4. Section 20-3112, Arizona Revised Statutes, is amended to read:

§ 20-3112. Applicability

This article does not apply to:
1. Health care services that are not covered by the enrollee's health plan.
2. Limited benefit coverage as defined in § 20-1137.



3. Charges for health care services that are subject to a direct payment agreement under § 32-3216 or 36-437.

~~4. Health plans that do not include coverage for out-of-network health care services, unless otherwise required by law.~~

~~5.~~ State health and accident coverage for full-time officers and employees of this state and their dependents that is provided pursuant to title 38, chapter 4, article 4.

~~6.~~ 5. A self-funded or self-insured employee benefit plan if the regulation of that plan is preempted by the employee retirement income security act of 1974 (P.L. 93-406; 88 Stat. 829; 29 United States Code section 1144(b)).

Sec. 5. Heading change

The section heading of Section 20-3113, Arizona Revised Statutes, is changed from "Surprise out-of-network bill; requirements; notice" to "SURPRISE OUT-OF-NETWORK BILLS AND AMBULANCE BALANCE BILLS PROHIBITED."

Sec. 6. Section 20-3113, Arizona Revised Statute, is amended to read:

§ 20-3113 SURPRISE OUT-OF-NETWORK BILLS AND AMBULANCE BALANCE BILLS PROHIBITED.

~~A. A bill for a health care service that was provided in a network facility by a health care provider that is not a contracted provider must meet one of the following requirements to qualify as a surprise out-of-network bill:~~

~~1. The bill was for emergency services, including under circumstances described by § 20-2803, subsection A and health care services directly related to the emergency services that are provided during an inpatient admission to any network facility.~~

~~2. The bill was for a health care service that was not provided in the case of an emergency and the health care provider or the provider's representative did not provide to the enrollee, or did not provide to the enrollee within a reasonable amount of time before the enrollee received the services, a written dated disclosure that contained the following information:~~

~~(a) Notice that contains the name of the billing health care provider and that states the health care provider is not a contracted provider.~~

~~(b) The estimated total cost to be billed by the health care provider or the provider's representative.~~

~~(c) Notice that the enrollee or the enrollee's authorized representative is not required to sign the disclosure to obtain medical care but if the enrollee or the enrollee's representative signs the disclosure, the enrollee may have waived any rights to dispute resolution under this article.~~

~~3. The bill was for a health care service that was not provided in the case of an emergency and the enrollee received the disclosure prescribed in paragraph 2 of this subsection, but the enrollee or the enrollee's authorized representative chose not to sign the disclosure.~~

A. ANY BILL IN VIOLATION OF THE FOLLOWING REQUIREMENTS IS A "SURPRISE OUT-OF-NETWORK BILL":

1. WHEN AN ENROLLEE RECEIVES HEALTH CARE SERVICES AT THE ENROLLEE'S NETWORK FACILITY, BUT THE SERVICES ARE RENDERED BY AN OUT-OF-NETWORK PROVIDER, THE ENROLLEE SHALL NOT BE CHARGED OR OWE AN AMOUNT MORE THAN THE COST SHARING REQUIREMENT THAT THE ENROLLEE WOULD HAVE OWED FOR RECEIVING THE SAME SERVICES FROM A CONTRACTED PROVIDER.

2. WHEN AN ENROLLEE RECEIVES EMERGENCY SERVICES AT AN OUT-OF-NETWORK FACILITY, THE ENROLLEE SHALL NOT BE CHARGED OR OWE AN AMOUNT GREATER THAN THE COST SHARING REQUIREMENT THAT THE ENROLLEE WOULD HAVE OWED FOR RECEIVING THE SAME SERVICES AT A NETWORK FACILITY BY A CONTRACTED PROVIDER.

3. WHEN AN ENROLLEE IS ATTENDED OR TRANSPORTED BY AN OUT-OF-NETWORK AMBULANCE, THE ENROLLEE SHALL NOT BE CHARGED OR OWE AN AMOUNT GREATER THAN THE COST SHARING REQUIREMENT THAT THE ENROLLEE WOULD HAVE OWED FOR RECEIVING THE SAME SERVICES BY AN IN-NETWORK AMBULANCE.

B. WHEN AN ENROLLEE IS ATTENDED OR TRANSPORTED BY AN IN-NETWORK AMBULANCE, THE ENROLLEE SHALL NOT BE DIRECTLY CHARGED OR OWE AN AMOUNT GREATER THAN THE ENROLLEE'S COST SHARING REQUIREMENTS, IN ADDITION TO WHICH THE AMBULANCE OR AMBULANCE SERVICE MAY BE REIMBURSED BY THE ENROLLEE'S INSURER AT THE AGREED ON RATES.

C. IF A HEALTH CARE PROVIDER, FACILITY, OR AMBULANCE SERVICE RECEIVES MORE IN PAYMENT FROM AN ENROLLEE THAN THE COST SHARING AMOUNTS PERMITTED BY THIS SECTION, THE HEALTH CARE PROVIDER, FACILITY OR AMBULANCE SERVICE SHALL REFUND ANY OVERPAYMENT TO THE ENROLLEE WITHIN 30 CALENDAR DAYS AFTER RECEIVING PAYMENT FROM THE ENROLLEE. IF THE HEALTH CARE PROVIDER, FACILITY OR AMBULANCE SERVICE DOES NOT REFUND ANY OVERPAYMENT TO THE ENROLLEE WITHIN 30 CALENDAR DAYS, INTEREST SHALL ACCRUE AT THE RATE OF 10 PERCENT PER ANNUM BEGINNING WITH THE DATE PAYMENT WAS RECEIVED FROM THE ENROLLEE. A HEALTH CARE PROVIDER, FACILITY OR AMBULANCE SERVICE SHALL AUTOMATICALLY INCLUDE IN THE REFUND TO THE ENROLLEE ALL INTEREST THAT HAS ACCRUED PURSUANT TO THIS SECTION WITHOUT REQUIRING THE ENROLLEE TO SUBMIT A REQUEST FOR THE INTEREST AMOUNT.

D. COST SHARING ARISING FROM SERVICES SUBJECT TO THIS CHAPTER SHALL BE COUNTED TOWARD ANY DEDUCTIBLE OR OUT-OF-POCKET LIMIT IN THE SAME MANNER AS COST SHARING WOULD BE ATTRIBUTED TO A CONTRACTED PROVIDER, NETWORK FACILITY, OR IN-NETWORK AMBULANCE.

~~B.~~ E. Notwithstanding any provision of this article, a health insurer and any health plan offered by a health insurer shall comply with chapter 17, article 1 of this title.

Sec. 7. Section 20-3113.01., Arizona Revised Statute, is added to read:

§ 20-3113.01 Fair payment standards.

A. WHEN AN ENROLLEE RECEIVES HEALTH CARE SERVICES AT THE ENROLLEE'S NETWORK FACILITY, BUT THE SERVICES ARE RENDERED BY AN OUT-OF-NETWORK PROVIDER, THE HEALTH INSURER SHALL REIMBURSE THE PROVIDER THE GREATER OF THE AVERAGE CONTRACTED RATE, OR 125 PERCENT OF THE AMOUNT MEDICARE REIMBURSES ON A FEE-FOR-SERVICE BASIS FOR THE SAME OR SIMILAR SERVICES IN THE GEOGRAPHIC REGION IN WHICH THE SERVICES WERE RENDERED.

B. WHEN AN ENROLLEE RECEIVES EMERGENCY SERVICES AT AN OUT-OF-NETWORK FACILITY, THE HEALTH INSURER SHALL REIMBURSE THE FACILITY OR PROVIDER THE GREATER OF THE AVERAGE CONTRACTED RATE, OR 125 PERCENT OF THE AMOUNT MEDICARE REIMBURSES ON A FEE-FOR-SERVICE BASIS FOR THE SAME OR SIMILAR SERVICES IN THE GEOGRAPHIC REGION IN WHICH THE SERVICES WERE RENDERED.

C. WHEN AN ENROLLEE IS ATTENDED OR TRANSPORTED BY AN OUT-OF-NETWORK AMBULANCE, THE HEALTH INSURER SHALL REIMBURSE THE AMBULANCE OR AMBULANCE SERVICE THE GREATER OF THE AVERAGE CONTRACTED RATE, OR THE RATE SET BY THE DEPARTMENT OF HEALTH SERVICES PURSUANT TO TITLE 36, CHAPTER 21.1, ARTICLE 2.

Sec. 8. Title 23, Chapter 2, Article 8 Arizona Revised Statutes, is amended by adding new section 23-363.01

§ 23-363.01. MINIMUM WAGE RATES FOR DIRECT CARE HOSPITAL WORKERS; DEFINITIONS.

A. AS OF THE EFFECTIVE DATE OF THIS SECTION, THE MINIMUM WAGE FOR EACH ELIGIBLE DIRECT CARE HOSPITAL WORKER SHALL BE FIVE PERCENT GREATER THAN THE ELIGIBLE DIRECT CARE HOSPITAL WORKER'S WAGE RATE IN THE PREVIOUS YEAR, WHICH IS THE HIGHEST HOURLY RATE OF BASE WAGES (OR, IF THE WORKER IS PAID ON A SALARY BASIS, THE EQUIVALENT BASE HOURLY RATE) THAT WAS PAID TO THE ELIGIBLE DIRECT CARE HOSPITAL WORKER IN THE YEAR BEFORE THE EFFECTIVE DATE OF THIS SECTION. THIS WAGE INCREASE SHALL ESTABLISH THE NEW MINIMUM RATE OF PAY FOR THE DIRECT CARE HOSPITAL WORKER WHICH SHALL REMAIN IN EFFECT FOR THE FULL CALENDAR YEAR UNTIL THE NEXT WAGE INCREASE IS DUE PURSUANT TO THIS SECTION, OR UNTIL THE EMPLOYER RAISES WAGES PURSUANT TO SUBSECTION C, OR UNTIL THE DIRECT CARE HOSPITAL WORKER IS NO LONGER EMPLOYED, WHICHEVER COMES FIRST.

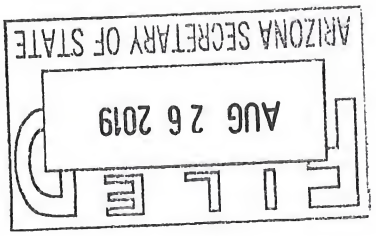
B. FOLLOWING THE INCREASE MADE AS OF THE EFFECTIVE DATE OF THIS SECTION, THE MINIMUM WAGE FOR ELIGIBLE DIRECT CARE HOSPITAL WORKERS SHALL BE INCREASED BY FIVE PERCENT EACH JANUARY 1 FOR THE NEXT THREE YEARS.

C. AN EMPLOYER MAY INCREASE BASE WAGES FOR DIRECT CARE HOSPITAL WORKERS ABOVE THE REQUIRED MINIMUM WAGE AT ANY TIME, BUT IS NOT PERMITTED TO REDUCE BASE WAGES BELOW THE AMOUNT ESTABLISHED BY THE REQUIRED MINIMUM WAGE.

D. THE MINIMUM WAGE FOR ANY NEWLY HIRED DIRECT CARE HOSPITAL WORKER MUST BE NO LESS THAN THE MINIMUM WAGE PAID TO ANY OTHER DIRECT CARE HOSPITAL WORKER WITH THE SAME JOB CLASSIFICATION OR WITH EQUIVALENT JOB RESPONSIBILITIES AND DUTIES AT THAT COVERED HOSPITAL.

E. BEGINNING THE FIFTH YEAR AFTER THE EFFECTIVE DATE OF THIS SECTION, NO FURTHER DIRECT CARE HOSPITAL WORKER MINIMUM WAGE INCREASES SHALL BE REQUIRED BY OPERATION OF THIS SECTION, BUT DIRECT CARE HOSPITAL WORKERS' BASE WAGES MUST REMAIN EQUAL TO OR GREATER THAN THEIR BASE WAGES AS OF DECEMBER 31 OF THE FOURTH YEAR AFTER THE EFFECTIVE DATE.

F. COVERED HOSPITALS SHALL ENSURE THAT ALL DIRECT CARE HOSPITAL WORKERS WHO WORK AT THAT COVERED HOSPITAL ARE COMPENSATED UNDER THE REQUIREMENTS OF THIS SECTION, REGARDLESS OF WHETHER THE DIRECT CARE HOSPITAL WORKER IS EMPLOYED BY THE COVERED HOSPITAL OR BY ANOTHER EMPLOYER.



G. AN EMPLOYER IS NOT PERMITTED TO OFFSET THE MINIMUM WAGES ESTABLISHED HEREIN BY REDUCING BENEFITS, PAID LEAVE, SHIFT DIFFERENTIALS, PREMIUMS, OR OTHER COMPENSATION PAID TO A DIRECT CARE HOSPITAL WORKER, INCLUDING NEWLY HIRED DIRECT CARE HOSPITAL WORKERS.

H. FOR THE PURPOSES OF THIS SECTION:

1. "COVERED HOSPITAL" MEANS ANY GENERAL HOSPITAL OR RURAL GENERAL HOSPITAL IN THE STATE OF ARIZONA, AS DEFINED IN ARIZONA ADMINISTRATIVE CODE SECTION R9-10-101, OR ANY SATELLITE FACILITY LICENSED UNDER A GENERAL HOSPITAL'S OR RURAL GENERAL HOSPITAL'S LICENSE PURSUANT TO SECTION 36-422, OTHER THAN A HOSPITAL OR FACILITY OPERATED BY THE FEDERAL GOVERNMENT, THE STATE, A COUNTY, OR A SPECIAL HEALTH CARE DISTRICT.

2. "ELIGIBLE DIRECT CARE HOSPITAL WORKER" MEANS ANY DIRECT CARE HOSPITAL WORKER WHO IS EMPLOYED AS OF DECEMBER 31 OF THE YEAR PRECEDING THE DATE ANY MINIMUM WAGE INCREASE IS DUE PURSUANT TO THIS SECTION.

3. "EMPLOY" HAS THE SAME MEANING AS IN SECTION 23-362.

4. "EMPLOYEE" HAS THE SAME MEANING AS IN SECTION 23-362.

5. "EMPLOYER" HAS THE SAME MEANING AS IN SECTION 23-362.

6. "DIRECT CARE HOSPITAL WORKER" MEANS ANY NON-MANAGERIAL WORKER EMPLOYED TO WORK AT OR BY A COVERED HOSPITAL TO PROVIDE DIRECT PATIENT CARE AND SERVICES DIRECTLY SUPPORTING PATIENT CARE, INCLUDING BUT NOT LIMITED TO NURSES, AIDES, TECHNICIANS, JANITORIAL AND HOUSEKEEPING STAFF, FOOD SERVICES WORKERS, AND NON-MANAGERIAL ADMINISTRATIVE STAFF.

7. "BASE WAGES" MEANS MONETARY COMPENSATION DUE TO AN EMPLOYEE BY REASON OF EMPLOYMENT, INCLUDING AN EMPLOYEE'S COMMISSIONS, BUT NOT TIPS, GRATUITIES, PAID LEAVE, OR BENEFITS.

Sec. 9. Title 36, Chapter 25, Arizona Revised Statutes, is amended by adding a new article 3 to read:

ARTICLE 3. HOSPITAL-ACQUIRED INFECTION CONTROL.

§ 36-2420. REDUCTION OF HOSPITAL-ACQUIRED INFECTIONS.

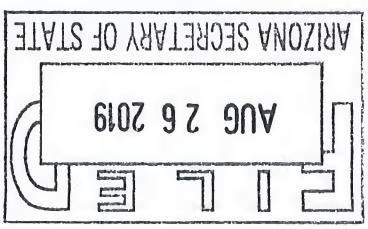
A. COVERED HOSPITALS ARE REQUIRED TO MEET THE HOSPITAL-ACQUIRED INFECTION STANDARD.

B. IN JANUARY OF EACH CALENDAR YEAR, COVERED HOSPITALS SHALL ASSESS WHETHER, FOR THE PREVIOUS YEAR, THEY WERE IN COMPLIANCE WITH THE HOSPITAL-ACQUIRED INFECTION STANDARD, AND SHALL REPORT ON THEIR PERFORMANCE TO THE DEPARTMENT BY NO LATER THAN FEBRUARY 1 OF THAT CALENDAR YEAR. THE REPORT SHALL INCLUDE ALL DATA SUFFICIENT FOR THE DEPARTMENT TO CONFIRM THAT THE COVERED HOSPITAL HAS MET THE HOSPITAL-ACQUIRED INFECTION STANDARD FOR THE RELEVANT PERIOD. THE COVERED HOSPITAL MUST EXPLAIN WHY ANY CATEGORY OF HOSPITAL COMPARE DATA FOR THE RELEVANT PERIOD IS REPORTED AS "NOT AVAILABLE." COVERED HOSPITALS SHALL PROVIDE ANY FOLLOW-UP INFORMATION REQUESTED BY THE DEPARTMENT WITHIN THIRTY (30) DAYS OF THE REQUEST.

C. THE DEPARTMENT SHALL HAVE FULL AUTHORITY TO TAKE ANY ACTION NECESSARY TO REDUCE THE INCIDENCE OF HOSPITAL-ACQUIRED INFECTIONS, INCLUDING THE AUTHORITY TO TAKE ANY ACTION TO ENFORCE THE PROVISIONS OF THIS ARTICLE AND TO ADDRESS COVERED HOSPITALS' NONCOMPLIANCE WITH THE HOSPITAL-ACQUIRED INFECTION STANDARD.

D. THE DEPARTMENT SHALL PROMPTLY MAKE SUCH CHANGES IN AND ADDITIONS TO REGULATIONS AS ARE NECESSARY TO FULLY IMPLEMENT THE PROVISIONS OF THIS SECTION. REGULATORY ACTIONS THE DEPARTMENT MAY TAKE TO ADDRESS NONCOMPLIANCE WITH THE HOSPITAL-ACQUIRED INFECTION STANDARD INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING:

1. REQUIRING INSPECTIONS OF COVERED HOSPITALS TO IDENTIFY PRACTICES CONTRIBUTING TO INFECTION PROBLEMS;



2. RECOMMENDING OR REQUIRING STAFFING STANDARDS TO ADDRESS INFECTION PROBLEMS;

3. COORDINATING WITH LOCAL HEALTH DEPARTMENTS TO IDENTIFY AND ADDRESS INFECTION PROBLEMS SPECIFIC TO LOCALITIES;

4. DEVELOPING TRAINING AND/OR LICENSING STANDARDS INTENDED TO REDUCE INFECTION RATES.

E. THE DEPARTMENT SHALL HAVE THE AUTHORITY TO AUDIT ANY COVERED HOSPITAL FOR COMPLIANCE WITH THIS ARTICLE. THE DEPARTMENT SHALL NOTIFY THE COVERED HOSPITAL TO BE AUDITED IN WRITING AT LEAST SEVEN (7) DAYS PRIOR TO THE DATE OF THE AUDIT. THE COVERED HOSPITAL TO BE AUDITED SHALL MAKE AVAILABLE FOR INSPECTION AND COPYING AT ALL REASONABLE TIMES ITS OWN BOOKS AND RECORDS, AS WELL AS THOSE OF ANY AFFILIATE OR RELATED ENTITY AS SHALL BE RELEVANT. IT SHALL BE UNLAWFUL TO REFUSE TO PERMIT SUCH AUDIT AFTER A LAWFUL DEMAND BY THE DEPARTMENT.

F. EVERY COVERED HOSPITAL SHALL PUBLICLY POST CLEAR AND EASILY COMPREHENSIBLE INFORMATION REGARDING ITS COMPLIANCE OR NON-COMPLIANCE WITH THE HOSPITAL-ACQUIRED INFECTION STANDARD FOR THE CURRENT REPORTED YEAR AND THE THREE (3) PRECEDING YEARS. IF THE HOSPITAL COMPARE DATA FOR THAT COVERED HOSPITAL IS REPORTED AS "NOT AVAILABLE," THE COVERED HOSPITAL SHALL PROVIDE A CLEAR EXPLANATION OF WHY. SUCH INFORMATION SHALL BE POSTED ON THE COVERED HOSPITAL'S PUBLIC WEBSITE AND IN CONSPICUOUS, CLEARLY VISIBLE LOCATIONS NEAR EACH PUBLIC ENTRANCE OF THE ESTABLISHMENT OR IN OTHER CONSPICUOUS LOCATIONS IN CLEAR VIEW OF THE PUBLIC AND EMPLOYEES WHERE SIMILAR NOTICES ARE CUSTOMARILY POSTED.

G. EVERY COVERED HOSPITAL SHALL MAINTAIN RECORDS FOR AT LEAST FOUR (4) YEARS SHOWING COMPLIANCE WITH THE REQUIREMENTS OF THIS ARTICLE.

H. THE DEPARTMENT SHALL IMPOSE FEES ON COVERED HOSPITALS TO RECOVER THE COSTS OF ADMINISTERING THIS ARTICLE. THE DEPARTMENT SHALL ESTABLISH IN THE STATE TREASURY THE REDUCTIONS OF HOSPITAL-ACQUIRED INFECTIONS FUND AND SHALL DEPOSIT THE FEES COLLECTED PURSUANT TO THIS SECTION INTO THE FUND.

I. THE DEPARTMENT SHALL IMPOSE A CIVIL PENALTY ON COVERED HOSPITALS THAT VIOLATE ANY PROVISION OF THIS ARTICLE OR OF ANY REGULATION PROMULGATED BY THE DEPARTMENT PURSUANT TO THIS ARTICLE. THE PENALTY SHALL BE FIVE HUNDRED DOLLARS PER VIOLATION. EACH DAY THAT A VIOLATION OCCURS CONSTITUTES A SEPARATE VIOLATION. ACTIONS TO ENFORCE THE COLLECTION OF THESE PENALTIES SHALL BE BROUGHT IN THE NAME OF THIS STATE BY DEPARTMENT, THE ATTORNEY GENERAL OR THE COUNTY ATTORNEY IN THE JUSTICE COURT OR THE SUPERIOR COURT IN THE COUNTY IN WHICH THE VIOLATION OCCURRED. THESE PENALTIES SHALL BE DEPOSITED IN THE REDUCTIONS OF HOSPITAL-ACQUIRED INFECTIONS FUND ESTABLISHED BY THIS ARTICLE AND SHALL BE USED FOR THE COSTS OF ENFORCING THE PROVISIONS OF THIS ARTICLE. INTEREST ON PENALTIES AND ON ALL OTHER MONETARY RELIEF SHALL ACCRUE AT THE RATE OF 10% PER ANNUM.

§ 36-2421. DEFINITIONS.

A. "DEPARTMENT" MEANS THE DEPARTMENT OF HEALTH SERVICES, OR ANY SUCCESSOR AGENCY WITH SIMILAR AUTHORITY AND RESPONSIBILITIES.

B. "COVERED HOSPITAL" MEANS ANY GENERAL HOSPITAL OR RURAL GENERAL HOSPITAL IN THE STATE OF ARIZONA, AS DEFINED IN ARIZONA ADMINISTRATIVE CODE SECTION R9-10-101, OR ANY SATELLITE FACILITY LICENSED UNDER A GENERAL HOSPITAL'S OR RURAL GENERAL HOSPITAL'S LICENSE PURSUANT TO SECTION 36-422, OTHER THAN A HOSPITAL OR FACILITY OPERATED BY THE FEDERAL GOVERNMENT, THE STATE, A COUNTY, OR A SPECIAL HEALTH CARE DISTRICT.

C. "HOSPITAL-ACQUIRED INFECTION STANDARD" INCLUDES:

1. A CLASSIFICATION OF "NO DIFFERENT THAN THE NATIONAL BENCHMARK" OR "BETTER THAN THE NATIONAL BENCHMARK" FOR ANY OF THE FOLLOWING TYPES OF HOSPITAL-ACQUIRED INFECTIONS BY THE CDC, AS OF THE MOST RECENT DATA COLLECTION PERIOD REPORTED IN THE HOSPITAL COMPARE DATA PUBLISHED BY THE CENTERS FOR MEDICARE &

MEDICAID SERVICES (CMS): *CLOSTRIDIUM DIFFICILE* (C. DIFF); CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI); CATHETER-ASSOCIATED URINARY TRACT INFECTIONS (CAUTI); SURGICAL SITE INFECTIONS (SSI), OR METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA);

2. SHOULD THE CDC AND CMS CEASE TO TRACK AND PROVIDE COMPARISONS OF COVERED HOSPITALS' C. DIFF., MRSA, CLABSI, CAUTI, OR SSI RATES TO NATIONAL BENCHMARKS, ANY APPROPRIATE ALTERNATIVE STANDARD THAT THE DEPARTMENT SHALL DEFINE; AND

3. SHOULD THE CDC AND CMS TRACK AND COMPARE OTHER HEALTHCARE-ASSOCIATED DISEASES AND ORGANISMS TO NATIONAL BENCHMARKS, INCLUDING BUT NOT LIMITED TO, OTHER MULTIDRUG RESISTANT BACTERIA, THEN THE DEFINITION OF "HOSPITAL-ACQUIRED INFECTION STANDARD" SHALL BE EXPANDED TO INCLUDE A CLASSIFICATION OF "NO DIFFERENT THAN THE NATIONAL BENCHMARK" OR "BETTER THAN THE NATIONAL BENCHMARK" FOR THOSE ADDITIONAL DISEASES AND ORGANISMS, ALSO AS OF THE MOST RECENT DATA COLLECTION PERIOD REPORTED IN THE HOSPITAL COMPARE DATA PUBLISHED BY CMS.

Sec. 10. Conflicts with Federal Law

Nothing in this Act shall be interpreted or applied so as to create any power or duty in conflict with federal law.

Sec. 11. Severability

If a provision of this Act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act that can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

Sec. 12. Savings Clause

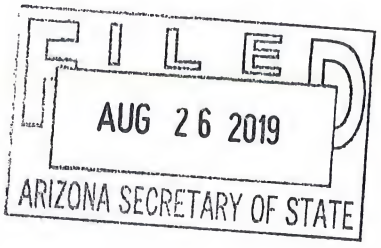
This act does not affect rights and duties that matured, penalties that were incurred and proceedings that were begun before the effective date of this Act.

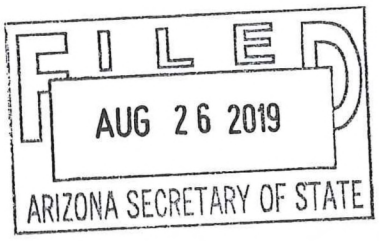
Sec. 13. Legal Defense

The People of Arizona desire that this initiative, if approved by the voters, be defended if it is challenged in court. They therefore declare that the political committee registered to circulate petitions and campaign in support of the adoption of this initiative, or any one or more of its officers, have standing to defend this initiative on behalf of and as the agent of the People of Arizona in any legal action brought to challenge the validity of this initiative.

Sec. 14. Short Title

This act may be cited as the "Stop Surprise Billing and Protect Patients Act."




FILED
AUG 26 2019
ARIZONA SECRETARY OF STATE